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State/Territory Name: Georgia

State Plan Amendment (SPA) #:13-015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 18, 2014

Dr. Jerry Dubberly, Chief
Medical Assistance Plans
Georgia Department of Community Health
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303

RE: Title XIX State Plan Amendment (SPA), Transmittal # GA 13-015

Dear Dr. Dubberly:

We have reviewed the proposed Georgia State Plan Amendment 13-015, which was submitted to the Atlanta Regional Office on November 15, 2013. The SPA implements a medical coordination program for the aged, blind, and disabled population in the state plan.

Based on the information provided, the Medicaid State Plan Amendment GA 13-015 was approved on February 11, 2014. The effective date of this amendment is October 1, 2014. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Kia Carter-Anderson at (404) 562-7431 or Kia.Carter-Anderson@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: **T.N. No.: 13-015**	2. STATE **GEORGIA**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR **CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES**	4. PROPOSED EFFECTIVE DATE **October 1, 2014**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN **X** AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **42 C.F.R. §§ 438.6(c), 438.50, and 440.168**	7. FEDERAL BUDGET IMPACT: **FFY 2014 - $ 0** **FFY 2015 - ($ 3,833,889)** **FFY 2016 - ($10,088,154)** **FFY 2017 – ($15,205,594)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-F, Pages 1 - 14**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **N/A**

10. SUBJECT OF AMENDMENT: **This State Plan Amendment will implement medical coordination services for eligible Medicaid members who are aged, blind, and disabled.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: **Single State Agency Comments Attached**

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Jerry Dubberly	**Department of Community Health** **Division of Medicaid** **2 Peachtree Street, NW, 36th Floor** **Atlanta, Georgia 30303-3159**
14. TITLE: Chief, Division of Medicaid	
15. DATE SUBMITTED: 11-15-13	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 11-15-13	18. DATE APPROVED: 02-11-14
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10-01-14	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns

23. REMARKS:

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Georgia enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

The Georgia Department of Community Health (DCH) will procure a single statewide vendor to provide a Medical Coordination Program for Medicaid Members who are aged, blind and disabled (ABD) as identified by Members' Categories of Aid. The vendor is expected to achieve DCH's healthcare goals and Member health outcomes, and serve as an administrative agent of the State. The Medical Coordination Program will provide:

- Person-centered Medical Coordination for all eligible Members
- Intensive Medical Coordination services for targeted high-risk, impactable populations
- A medical home to coordinate and manage care for participants receiving Intensive Medical Coordination services
- Care Coordinators to assist eligible Members in obtaining needed medical services

With the exception of partial benefit dual eligible Members and those Members enrolled in the Georgia Families program (Medicaid managed care), all other Medicaid Members will be eligible to receive services through the Medical Coordination Program. Thus, the Medical Coordination Program includes individuals who are dually eligible, enrolled in a Home- and Community-Based

Citation	Condition or Requirement

Services (HCBS) waiver program or residing in a long-term institutional setting. DCH and its sister agencies will continue to administer State Plan benefits and HCBS waiver programs and to provide non-conflicting case management services.

All Members will receive Core Coordination Services to include Member education, call center services and access to a twenty-four (24) hour nurse line. Members with chronic conditions, behavioral health conditions, co-morbidities or other complex diagnoses deemed "high-risk and impactable" will have the option to receive Intensive Medical Coordination services to include a health risk assessment, establishment of a health care plan, assistance with establishing a medical home and interdisciplinary team care management. The Medical Coordination Program vendor must develop and maintain a Primary Care Case Management (PCCM) network to ensure Members will have adequate access to medical home providers.

The vendor will use a variety of mechanisms to identify Members potentially eligible for Intensive Medical Coordination services including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, predictive modeling and other data analyses. For potential Intensive Medical Coordination participants, the vendor must complete a comprehensive health risk assessment that evaluates the Member's medical condition(s), including physical, behavioral, social and psychological needs. The goals of the health risk assessment are to confirm the Member's need for Intensive Medical Coordination, identify the Member's existing and/or potential health care needs, determine the types of services needed by the Member, and begin to develop the health care Plan and treatment team. Health risk assessments may require on-site visits to a Member's residence, doctor's office, pharmacy, or other locations. Meeting the Members "where they are" will be an important component of interaction and engagement.

Members in the Medical Coordination Program will be advised by DCH and the Medical Coordination Program vendor on the provisions for opting out of Intensive Medical Coordination services. The vendor will inform Members and/or Members' legal guardians, as well as primary care providers, specialists and/or behavioral health providers that the Member has been identified as meeting the criteria for Intensive Medical Coordination services. The notification must provide a description of the Intensive Medical Coordination services, the Intensive Medical Coordinator's contact information and phone number, patient confidentiality and protection information, and the mechanism for opting out should the Member and/or Members' legal guardians prefer not to receive Intensive Medical Coordination services. In addition, the vendor's call center staff will be required to

Citation	Condition or Requirement

assist those Members wishing to either opt-out of or opt back into Intensive Medical Coordination services. The vendor's Medical Coordination Program website will also provide information to Members on the provisions for opting out or into Intensive Medical Coordination services.

Members eligible to receive Intensive Medical Coordination services will also be assisted by the vendor in selecting a medical home provider which may be a primary care provider, specialist, behavioral health provider or Patient-Centered Medical Home. If a Member is unable to select a medical home provider, the vendor will assign such a provider based on an algorithm approved by DCH and which heavily weighs the practitioner the Intensive Medical Coordination participant is frequenting the most.

DCH expects the Program and vendor to achieve substantive improvements in service, access, appropriateness, and health and quality outcomes while reducing expenditures over the course of the contract. A significant component of the Program is a Value-Based Purchasing (VBP) approach that recognizes and rewards positive financial, and health and quality outcomes achieved through this Program. To be successful, DCH believes a VBP approach must align payer, Offeror and Provider goals, objectives and incentives. The VBP model performance targets will include transactional and quality measures and indicators. A percentage of the fees paid by DCH to the vendor will be withheld and returned to the vendor if these performance measures are met.

DCH will reimburse the selected Offeror on a Per Member Per Month (PMPM) basis for all Members, regardless of whether the Member is eligible for or is an Intensive Medical Coordination Participant receiving Intensive Medical Coordination services. This PMPM payment to the vendor will include the provision of core services to all Members, Intensive Medical Coordination services for eligible Members and a Case Management fee for medical homes selected or assigned to Members receiving Intensive Medical Coordination services.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
_X__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: ____i. fee for service; ____ii. capitation; _X__iii. a case management fee; _X__iv. a bonus/incentive payment; ____v. a supplemental payment, or ____vi. other. (Please provide a description below).
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). __X__i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. __X__ii. Incentives will be based upon specific activities and targets. __X__iii. Incentives will be based upon a fixed period of time. __X__iv. Incentives will not be renewed automatically. __X__v. Incentives will be made available to both public and private PCCMs. __X__vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____vii. Not applicable to this 1932 state plan amendment.

Citation		Condition or Requirement
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The procurement for a Medical Coordination Program for eligible Members is the result of extensive public input and program analyses. In August 2011, DCH began an effort to analyze the Medicaid program to identify opportunities to achieve efficiencies and to provide improved outcomes and quality of care for Members. These efforts include a transparent, collaborative process working with stakeholders through focus groups and ongoing taskforces to obtain insights about challenges and opportunities for improvement. Stakeholders with which DCH has collaborated include Medicaid Members, advocates, Providers, legislators and Offerors. DCH formed three task forces that meet regularly to provide input: Provider; Aged, Blind and Disabled; and Children and Families Task Forces. DCH also convened a Mental Health and Substance Abuse Workgroup. Common themes identified by these groups are as follows: • Due to the often chronic and serious nature of their health issues, the ABD population – including individuals in long-term care and disability programs – would significantly benefit from intensive care management approaches. • Care coordinators should be used to help all ABD Members obtain timely needed services. • A true focus on quality and outcomes is critical to the success of the Medicaid program. • A person-centered model with a holistic view of an individual's needs is essential to quality outcomes. • The ABD population is not homogenous in terms of their medical needs. Some Members are aged or have a disability, but they are otherwise healthy. Other Members of the ABD population have high acuity levels and intense medical needs.

Citation	Condition or Requirement

- Due to the often chronic and serious nature of their health issues, the ABD population – including individuals in long-term care and disability programs – would significantly benefit from intensive Care Management approaches or integrated healthcare coordination.
- Member linkages to Patient-Centered Medical Homes are strongly encouraged for those who have the highest level of needs.
- Improved care coordination for Medicaid/Medicare dually-eligible Members is needed.

Examples of additional methods that DCH will employ to continue collecting public input during and after implementation are as follows:

- Inclusion of stakeholders such as established Task Forces, providers, members and advocates on an as needed basis
- Requirement for the vendor to identify and work with DCH to resolve issues pertaining to access to health care services, to communicate and educate members, providers and caregivers and to regularly report findings to the Medicaid Agency
- Inclusion of related topics in the agenda for the Medical Care Advisory Committee on an as needed basis

1932(a)(1)(A)

5. The state plan program will___/will not_X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary__X___ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary) Statewide_____X_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary) Statewide_____

Citation	Condition or Requirement
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met. Not applicable.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. __X__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ____The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met. Not applicable.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. __X__The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. __X__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. Not applicable.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. __X__The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.

Citation	Condition or Requirement
45 CFR 74.40	8. __X__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. There will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. _X___Recipients who are also eligible for Medicare. There will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. _X___Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

Citation	Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. _X__Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _X__Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Children receiving services funded by Title V are enrolled in the Children's Medical Services Program administered by the Georgia Division of Public Health. This program provides comprehensive, coordinated, community-based, Title V services for children birth to age 21 with chronic medical conditions. Medical eligibility includes but is not limited to:

a. Burns
b. Cardiac conditions
c. Cystic fibrosis
d. Hearing disorders
e. Spina bifida
f. Cerebral palsy
g. Diabetes mellitus
h. Vision disorders
i. Craniofacial anomalies (including cleft lip/palate)
j. Gastrointestinal disorders
k. Neurological and neurosurgical conditions including epilepsy and

Citation	Condition or Requirement

hydrocephalus
l. Orthopedic and/or neuromuscular disorders (scoliosis)
m. Congenital or traumatic amputations of limbs

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_X__iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_X__i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self-identification)*

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

i. Children under 19 years of age who are eligible for SSI under title XVI;

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive

Citation	Condition or Requirement

intensive medical coordination may decline to receive, or opt out, of services.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

i. Recipients who are also eligible for Medicare.

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive

Citation	Condition or Requirement

intensive medical coordination may decline to receive, or opt out, of services.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

- SSI
- Public Laws
- Institutionalized (Nursing facility, inpatient hospice, long-term hospital, etc.)
- Home and Community Based Waiver
- Deeming Waiver
- Medically Needy

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state

Citation	Condition or Requirement

records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

All members will receive provider services through the fee-for-service delivery system and so existing provider-recipient relationships may continue at the member's option.

Members identified to receive intensive medical coordination services will be formally assigned to a medical home. Members may voluntarily select or the vendor may assign members to a medical home. The vendor will determine if the member has a primary source of care that is participating in the Medical Coordination Program, and if so, assign the member to that provider.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

The provider networks for Medicaid members are limited to Medicaid-participating providers.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

DCH is contracting with one vendor to provide services to eligible populations. All members will have access to a minimum set of general coordination services and be subject to predictive modeling

Citation	Condition or Requirement
	and other analyses by the vendor to identify the need for intensive medical coordination services. Members identified by the vendor as high-risk and impactable will be eligible to receive intensive medical coordination services. The vendor must have a process for individuals to decline to receive, or opt out of, Intensive Medical Coordination services.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will____/will not__X__ use a lock-in for managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____.
	Medical Coordination program services will be available to Medicaid members in the fee-for-service delivery system at the time that they are determined eligible under an aged, blind and disabled eligibility category. The vendor will conduct regular analyses to identify eligible members who may be in need of intensive medical coordination services, and contact those members to enroll in those services. The vendor must have a process for individuals to decline to receive, or opt out of, Intensive Medical Coordination services.
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*
	DCH has a process in place to mail notification to the member of the availability of services the vendor will provide.
	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
	Not applicable.
	v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Citation	Condition or Requirement

Not applicable.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Not applicable.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. X The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. ____The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

Not applicable.

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

_X_This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_X_ This provision is not applicable to this 1932 State Plan Amendment.

5. __X_ The state applies the automatic reenrollment provision in accordance

Citation		Condition or Requirement
		with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ___This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J.	Disenrollment 1. The state will___/will not_X__ use lock-in for managed care. 2. The lock-in will apply for ____ months (up to 12 months). Not applicable. 3. Place a check mark to affirm state compliance. _X_The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c). 4. Describe any additional circumstances of "cause" for disenrollment (if any). Members may opt out of receiving intensive care management services at any time for any reason.
	K.	Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10		_X___The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L.	List all services that are excluded for each model (MCO & PCCM) Services will continue to be provided through the fee-for-service delivery system.
1932 (a)(1)(A)(ii)	M.	Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Citation	Condition or Requirement

1. The state will__X___/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ___X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   DCH has elected to contract with a single vendor that has targeted expertise to effectively provide intensive medical coordination for members who are aged, blind and disabled and have unique and complex health care needs. This program is meant to provide additional coordination to meet the needs of eligible members who remain in the fee-for-service delivery system, and DCH believes that one vendor is sufficient to meet the requirements of the contract and the population being served.

4. ____ The selective contracting provision in not applicable to this state plan.